New Patient Application

CONNECTION TO CARE™
PATIENT ASSISTANCE PROGRAM

READ THE INSTRUCTIONS ON THE OTHER SIDE FIRST. PLEASE PRINT CLEARLY IN THE SHADED AREAS. MAIL THE ORIGINAL APPLICATION TO THE ADDRESS BELOW.

PATIENT INFORMATION

Patient name

Patient address Apartment

City State Zip

Telephone number **Best time to call**

Date of birth (month / day / year) **Social Security number**

Gender Male ☐ Female ☐ **Ethnic origin** *(optional)* Asian ☐ Black ☐ Hispanic ☐ White ☐ Other ☐

Are you in any benefit program that helps pay for prescription drugs?
SEE THE OTHER SIDE FOR EXAMPLES. IF YES, YOU CANNOT RECEIVE MEDICATION FROM THIS PROGRAM. Yes ☐ No ☐

Number of dependents in your household *(including yourself)* **Are you married?** Yes ☐ No ☐

If you are single, is your total yearly household income **less than $19,000**, or
If you are married, or have dependents, is your total yearly household income **less than $31,000**? Yes ☐ No ☐

Did you file a Federal tax return for the most recent tax year?
IF NO, YOU MUST SIGN BOTH THE **PATIENT INFORMATION** SECTION **AND** THE **REQUEST FOR IRS VERIFICATION** BELOW. Yes ☐ No ☐

Total yearly income for your entire household $ **Are you enrolled in Medicare?** Yes ☐ No ☐

PFIZER MAY CHECK THE INFORMATION ON YOUR APPLICATION. WE MAY ASK YOU FOR MORE FINANCIAL AND INSURANCE INFORMATION. PFIZER RESERVES THE RIGHT TO CHANGE OR CANCEL THE *CONNECTION TO CARE* PROGRAM AT ANY TIME.

By signing below, I affirm that my answers, and my proof-of-income documents, are complete and accurate to the best of my knowledge.

Patient signature for application X Date

May Pfizer use your information to contact you about your experience with the *Connection to Care* program? Yes ☐ No ☐

REQUEST FOR IRS VERIFICATION THAT YOU DID NOT FILE A TAX RETURN

If you did not file a Federal tax return for tax year 200___, sign again below in this section to agree that:

- You are asking the IRS to send confirmation to Pfizer that you did not file a Federal tax return for the tax year 200___.
- The IRS does not control how Pfizer uses this information.
- The IRS may call you to make sure you want to share this confirmation.

IRS: PLEASE SEND VERIFICATION TO
Pfizer Connection to Care
PO Box 66557
St. Louis, MO 63166-6557

Patient signature for IRS request X Date

HEALTHCARE PROVIDER TO BE COMPLETED BY THE PRACTITIONER WHO WRITES THE PRESCRIPTION

Name and professional designation of healthcare provider

DEA # *(if none available, state license #)* Expiration date

C/O LA COUNTY DEPT. OF MENTAL HEALTH
Name of clinic or hospital *(if applicable)*

Name and title of office contact person

213-738-3116
Telephone Fax

550 S. VERMONT. ROOM 903
Mailing address *(for correspondence)* Suite

LOS ANGELES, CALIF. 90020
City State Zip

☑ *Shipping address same as mailing address*

Shipping address *(We cannot accept a PO Box)* Suite

City State Zip

By signing below, you the healthcare provider understand and agree that:

- Any medications supplied by Pfizer as a result of this order form are for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid or other benefit provider) for reimbursement.
- Pfizer may contact the patient directly to confirm receipt of medications.
- Pfizer may change or cancel this program at any time.

Original signature of practitioner X Date

Clear entire form

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names | Birth Date | MIS Number

Street Address | City, State, Zip

AUTHORIZES:

Name of Agency

Street Address

City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

PFIZER CONNECTION TO CARE
Name of Health Care Provider/Plan/Other

PO BOX 66585
Street Address

ST. LOUIS, MO 63166 - 6585
City, State, Zip Code

INFORMATION TO BE RELEASED:

- ☐ Assessment/Evaluation
- ☐ Laboratory Results
- ☐ Entire Record (Justify)
- ☒ Other (Specify): PATIENT FINANCIAL INFORMATION
- ☐ Results of Psychological Tests
- ☒ Medication History/ Current Medications
- ☐ Diagnosis
- ☐ Treatment

PURPOSE OF DISCLOSURE: (Check applicable categories)

- ☒ Client's Request
- ☐ Other (Specify):

RISPERDAL PATIENT ASSISTANCE PROGRAM

Will the agency receive any benefits for the disclosure of this information? ☐ Yes ☒ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____	_____
Contact person	Agency Name
_____	_____
Street Address	City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____	_____
Signature of Client / Personal Representative	Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year